U.S. Legal Services
Providing legal benefit plans.

NON-NETWORK CLAIM FORM

Plan Member and Client Information

Plan Member's Name | USL Member Number (Required)

Address

City, State, Zip

Plan Member Telephone Contact Number

Relationship to Plan Member □ Self □ Spouse □ Child □ Other: DOB:

Authorized Signature

X _____ Date: _____

I authorize the release of any legal information necessary for this claim

Claim Information

First Contact Date: _____

Date suit or charges filed: _____

Case Number: _____

Covered Legal Issue

Attorney Name and Address

COPIES OF ATTORNEY BILLING AND PROOF OF PAYMENT MUST BE ATTACHED BEFORE REQUEST FOR REIMBURSEMENT CAN BE SUBMITTED FOR APPROVAL

U.S. Legal Services, Inc.
8133 Baymeadows Way
Jacksonville, Florida 32256
800-356-LAWS
904-730-0023 Facsimile

By Submitting this claim, I certify I agree to the terms of the current Attorney Reimbursement Fee Schedule. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony of the third degree. All claim documentation must be submitted with claim or claim for payment will be denied.